

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014093

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 30 Primary Registration District No. 4038 Registrar's No. 27

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10080

20080

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

FILED MAY 7 1962

1. PLACE OF DEATH
a. COUNTY Bentonb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN WARSAWLength of stay in lb
yearsc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION -Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY BENTONc. CITY OR TOWN WARSAWInside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

ClydeM^cCARTY

4. DATE OF DEATH

Month

Day

Year

Apr 29 1962

5. SEX

Male

6. COLOR OR RACE

White7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

Mar 2, 1891

9. AGE (last birthday)

71

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Merchant10b. KIND OF BUSINESS OR INDUSTRY
Grocery Store11. BIRTHPLACE (City and state or country)
Clifton City, Mo12. CITIZEN OF WHAT COUNTRY
U.S.A

13a. FATHER'S NAME

Milton M. M^cCarty

13b. MOTHER'S MAIDEN NAME

Lula Bridges

14. NAME OF HUSBAND OR WIFE

Maude M^cCarty15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No16. SOCIAL SECURITY NO.
No17. INFORMANT Address
Maude M^cCarty - Warsaw, Mo18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

TOXIC COMA

INTERVAL BETWEEN ONSET AND DEATH

ONE WEEK

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

ACUTE HEPATIC INSUFFICIENCYONE MONTH

DUE TO (c)

CHRONIC PORTAL CIRRHOSISTWO YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.
Month, Day, Year20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from APRIL 1, 1960 to APRIL 29, 1962 saw her last on APRIL 29, 1962
Death occurred at 5:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Busschaller DO

(Degree or title)

22b. ADDRESS

WARSAW, MO.

22c. DATE SIGNED

5-1-62

23a. BURIAL, CREMATION, or REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

May 2, 1962

ADDRESS

Warsaw

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

May 2, 1962Jas. A. Logan

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John F. Reser

Licensed Embalmer No.

4098

P. O. Address

Warsaw

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.